The Frankenstein Monster

Medicaid
Medicaid Jargon

- Waivers
- Fee for Service
- 1915c
- Demonstration
- Medicaid
- Capitation
- Title 19
- State Plan Amendment
- Transportation
- Dually Eligible
- EPSDT
- Managed Care
- Spend Down
- Budget Neutrality
History and Background

- Medicare and Medicaid legislation passed in 1965
  1. Part of the Social Security Act (passed in 1935)
  2. Title 18 – Medicare
  3. Title 19 – Medicaid
- Who received the first Medicare card?
What's the difference?

- **Medicare** – national health insurance for people ≥ 65 and some people who have disabilities
  1. If you’ve performed paid work, you’ve paid into it
  2. Part A – hospital insurance
  3. Part B – medical insurance (e.g. doctor visits)
  4. Part C – managed care plan for hospital and medical coverage (Medicare Advantage)
  5. Part D – prescription drug coverage
What's the difference?

- **Medicaid** – Health care program for people with very low incomes who also meet some other eligibility criteria:
  1. Age (child or elder)
  2. Condition (pregnancy)
  3. Disability

- States don't have to participate, but all states now do
Medicaid

- State-run program jointly financed by federal and state governments
  1. Federal money in the form of the matching of state money
  2. Each state has a different match rate each year based on a variety of economic factors (FMAP)
- Certain people can be covered by both Medicare and Medicaid
Medicaid's Three Big Rules

- Services must be offered **statewide**
- Services must be **comparable**, i.e. the same for everyone
- Beneficiaries must be offered **freedom of choice** among qualified providers
Who Is Covered By Medicaid?

- Low income and age
- Low income and disability
- Low income and pregnant/caretaker
- Optional populations (e.g. medically needy)
What Flexibility Do States Have?

- Optional eligibility requirements
- Optional benefits
- Limited or alternative benefits (more on this later)
- Service delivery mechanisms
  - Fee for service (FFS)
  - Primary Care Case Management (PCCM)
  - Capitated managed care
Medicaid State Plan

- Specifies the eligibility groups served, benefits provided, and how the program is operated
- Provides the basis for a state’s claim for Federal financial participation (FFP)
- The state plan and all subsequent amendments must be reviewed and approved by the federal government
What Is Covered By Medicaid?

- Mandatory Services
  - Inpatient Hospital
  - Outpatient Hospital
  - Rural Health Clinic Services
  - Federally Qualified Health Center (FQHC) Services
  - Lab and X-Ray Services
  - Transportation to medical care
  - Home Health
  - EPSDT “Kan Be Healthy”
  - Physician Services
  - Dental Services (for children)
  - Tobacco cessation counseling for pregnant women
  - Nursing Facilities
  - Family Planning
  - Pregnancy Care
  - Some Other Practitioner Services
What Is Covered By Medicaid?

• Optional Services
  - Prescribed Drugs
  - Clinic Services
  - Physical Therapy
  - Occupational Therapy
  - Speech, Hearing and Language
  - Prosthetic Devices
  - Optometric Services
  - Eyeglasses
  - Rehabilitation Services
  - Health Homes
  - Respiratory Care Services
  - Other diagnostic/screening services
  - Mental Health
  - Hospice
  - Targeted Case Management
  - Podiatry
  - Chiropractic
  - HCBS, ICF-MR (ICF/IID)
Working Healthy

Working Healthy incentivizes employment for people with disabilities.

Working Healthy benefits include:
- Full Medicaid coverage
- Elimination of spend down or client obligation
- Ability to earn more income without loss of medical coverage
- Affordable premiums
- Allowance of higher savings than traditional Medicaid
- Help with Medicare expenses
- Personal assistance services under WORK
- Benefits planning and assistance
- Long term supports via WORK
WORK

• Individuals eligible for *Working Healthy* receive personal assistance and other services through *WORK*

• State Plan “Alternative Benefit Plan” consisting of services approved by CMS in September 2014

  > Personal Assistance Services (PAS)
  > Assistive Services
  > Independent Living Counseling (ILC)
How Does Medicaid Work In Kansas?

- Single State Medicaid Agency (SSMA) – KDHE – responsibilities:
  1. Maintains State Plan
  2. Sets eligibility policy, within federal guidelines, to allow people to apply for Medicaid
  3. Contracts for Medicaid Management Information System (MMIS)
  4. Contracts with three managed care organizations (MCOs)
Kansas Department of Health & Environment

- Primary contact with Centers for Medicare and Medicaid Services (CMS) at the federal level for:
  1. Drawing down federal funds
  2. Maintaining program integrity and combating fraud and abuse
  3. Submitting federal reports
Defining Medicaid Policy: Federal Level

- Federal Laws
- CMS
  - Regulations (general Medicaid as well as specific managed care regulations)
  - Medicaid Manual
  - Informal Guidance
  - Waivers
Defining Medicaid Policy: State Level

- State Laws
- State Regulations
- Single State Agency
  - State Plan
  - 1115 Demonstration Waiver
What questions do you have so far?
What is KanCare?

- Medicaid + Children’s Health Insurance Program (CHIP) = KanCare

1. CHIP (Title 21 of Social Security Act) covers children in families with incomes too high to qualify for Medicaid
2. Covers children up to age 19
3. Benefits almost identical to Medicaid
Managed Care

- KDHE contracts with three managed care organizations (MCOs) who:
  1. Enroll providers
  2. Pay for services
  3. Receive a monthly payment for each person in KanCare
  4. Are at financial risk for almost all the costs of care for KanCare members
Payment for KanCare Services

- Capitated per member per month (PMPM) payment made to KanCare MCOs for each KanCare member – 56 rate cells
- Federal government matches those payments (approximately 60 cents for every dollar) – CHIP and some specific services matched at a higher rate
- Providers bill the MCOs for services and are paid, generally, on a fee for service basis
KanCare Policy Development

HHS Sub-Cabinet (led by Dr. Colyer)

KanCare Steering Committee (KDHE + KDADS)

Centers for Medicare and Medicaid Services (CMS)

KDHE (Single State Medicaid Agency)

KDADS  KDHE  DCF  DOC
Agency Roles

**KDHE**
- Responsible for:
  - Physical health care services
  - 1115 Medicaid Demonstration Waiver
  - Medicaid Management Information System (MMIS)
  - Medicaid Program Integrity
  - Eligibility policy
  - Managing KanCare Eligibility Clearinghouse and determining eligibility
  - KanCare MCO contract management and compliance

**KDADS**
- Oversight of:
  - Behavioral health care services
  - HCBS (1915(c)) waivers
  - Nursing Facilities
  - State MH and I/DD Hospitals

**DCF**
- Implementation of eligibility policy for children in custody
MMIS: A Complex System

Clearinghouses

KEES

CMS

Beneficiaries

Other Contractors

Employers

KDADS

Affiliated Providers (hospitals, physicians, MCOs)

Other Insurance Companies

March & April 2016
Spring Medicaid Training
Medicaid As An Insurer

- Medicaid is the 3rd largest provider of health benefits coverage in Kansas after Blue Cross/Blue Shield and Medicare
- Single largest insurer of children
- Medicaid pays for about 40% of births in Kansas
- Medicaid pays for most mental health services, both nationally and in Kansas
Who Uses Medicaid in Kansas?

Average Monthly Members in Kansas Medical Assistance Programs: FY 11-15

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Families</td>
<td>210,120</td>
<td>227,033</td>
<td>231,463</td>
<td>240,378</td>
<td>250,653</td>
</tr>
<tr>
<td>Disabled</td>
<td>62,858</td>
<td>62,837</td>
<td>62,531</td>
<td>62,871</td>
<td>59,958</td>
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<tr>
<td>CHIP</td>
<td>43,226</td>
<td>47,240</td>
<td>51,332</td>
<td>56,758</td>
<td>54,417</td>
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<tr>
<td>Aged</td>
<td>39,178</td>
<td>40,731</td>
<td>42,116</td>
<td>43,885</td>
<td>43,079</td>
</tr>
<tr>
<td>Foster Care and Adoption</td>
<td>14,244</td>
<td>14,491</td>
<td>14,972</td>
<td>15,282</td>
<td>15,862</td>
</tr>
<tr>
<td>Other Populations</td>
<td>1,569</td>
<td>1,541</td>
<td>1,606</td>
<td>1,687</td>
<td>1,727</td>
</tr>
<tr>
<td>MediKan</td>
<td>1,325</td>
<td>900</td>
<td>654</td>
<td>660</td>
<td>694</td>
</tr>
</tbody>
</table>
How Does Someone Apply for KanCare?

- Through KanCare Eligibility Clearinghouse (in Topeka)
  1. Children (including CHIP)
  2. Pregnant women
  3. Caretakers
  4. Disabled
  5. Seniors
- Two different application forms; can also apply online
What Is A Waiver?

- States can ask the federal government to waive (set aside or ignore) one or more Medicaid rules
- Usually ask to waive one of the big three rules
- Home and Community Based Services (HCBS) waivers are the most common (also referred to as 1915(c) waivers)
1915(c) (HCBS) Waivers

- Targeted population (waive the comparability rule)
- Special package of services (waive the comparability rule)
- Can be limited to a certain number of people (waive the comparability rule)
- Designed to bring someone out of nursing facility or other institution (institutional equivalent)
1915(c) (HCBS) Waivers

- Services provided through an HCBS waiver are usually not covered by any health insurance.
- HCBS waiver services can have limits and be limited to sub-groups within the waiver (e.g., certain levels of a service or certain number of hours).
- HCBS waivers can also provide extended State Plan services.
- Seven HCBS waivers in Kansas.
Kansas 1915(c) (HCBS) Waivers

- Autism (children only, begins before age 6)
- Frail Elderly – FE (65+)
- Intellectual/Developmental Disability - IDD (age 5+)
- Physical Disability – PD (ages 16-64)
- Seriously Emotionally Disturbed - SED (children only, ages 4-21)
- Technology Assisted – TA (children only, 0-21)
- Traumatic Brain Injury – TBI (ages 16-64)
Kansas 1915(c) (HCBS) Waivers

- Each requires a **functional** eligibility assessment in addition to a **financial** eligibility determination
- Functional assessments completed by a third party – not state or MCOs
- Those who receive HCBS can also receive any medically necessary State Plan services
1115 Research & Demonstration Waiver

- Part of the original Social Security Act
- Used to be relatively rare, but now 30 states have one or more 1115 waiver
- Still not as common as 1915(c) waivers
- Not popular with CMS staff because they are very individualized and most of the writing is done by CMS and not the state
- Kansas was granted an 1115 waiver effective January 1, 2013
KanCare 1115 Research & Demonstration Waiver

- How Kansas operates both its State Plan and HCBS waivers
- Authority to require most beneficiaries to receive all their services through managed care plans
- Authority for MCOs to manage HCBS waiver services along with physical and behavioral health services
- Over 100 special terms and conditions (STC)
  - KanCare Ombudsman
  - Quarterly reporting
Medicaid Waiver Costs

• 1915(c) or HCBS waivers must be cost neutral – per capita costs do not exceed average cost of institutional settings

• 1115 waivers must demonstrate budget neutrality – federal spending cannot exceed what would have been spent in the absence of the waiver
Making Changes to Medicaid

- State Plan – once submitted, is just amended when eligibility groups or services are changed or a new SSMA is designated
- 1915(c) waivers must be amended to change eligibility or services and must be renewed every 5 years after initial 3-year period
- 1115 waivers are approved for 5 years and then must be renewed or will expire; they can also be amended any time
Questions?
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Division of Health Care Finance
Kansas Department of Health & Environment
rross@kdheks.gov
http://www.kancare.ks.gov
http://www.kdheks.gov/
### Kansas Medical Assistance Standards

Standards in the Kansas Medical Assistance Programs – To be financially eligible, the total countable income must not exceed the income limit for the specified program. Income limits are based on the number of individuals included in the household size of the determination. Unless otherwise specified, all standards are monthly amounts.

1. **MAGI programs**

   The following chart outlines the income limits for the MAGI Poverty Level programs.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>113% Children ages 6 – 18</th>
<th>149% Children ages 1-5</th>
<th>171% PW &amp; Infants under age 1</th>
<th>M-CHIP 113 - 133% Children ages 6-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Limit</td>
<td>Upper Limit</td>
<td>Lower Limit</td>
<td>Upper Limit</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>1119</td>
<td>0</td>
<td>1475</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>1509</td>
<td>0</td>
<td>1989</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>1899</td>
<td>0</td>
<td>2503</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>2289</td>
<td>0</td>
<td>3017</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>2679</td>
<td>0</td>
<td>3531</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>3068</td>
<td>0</td>
<td>4045</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>3459</td>
<td>0</td>
<td>4561</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>3851</td>
<td>0</td>
<td>5077</td>
</tr>
<tr>
<td>Extra Person</td>
<td>392</td>
<td>517</td>
<td></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Household Size</th>
<th>134 - 166% Children ages 6–18 No premium</th>
<th>150 - 166% Children ages 1–5 No premiums</th>
<th>167 - 191% Children ages 0–18 $20 premium</th>
<th>192 - 218% Children ages 0–18 $30 premium</th>
<th>219 - 243% Children ages 0–18 $50 premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Limit</td>
<td>Upper Limit</td>
<td>Lower Limit</td>
<td>Upper Limit</td>
<td>Lower Limit</td>
</tr>
<tr>
<td>1</td>
<td>1,317.01</td>
<td>1644</td>
<td>1475.01</td>
<td>1644</td>
<td>1693.01</td>
</tr>
<tr>
<td>2</td>
<td>1,776.01</td>
<td>2217</td>
<td>1989.01</td>
<td>2217</td>
<td>2283.01</td>
</tr>
<tr>
<td>3</td>
<td>2,235.01</td>
<td>2789</td>
<td>2503.01</td>
<td>2789</td>
<td>2873.01</td>
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<tr>
<td>4</td>
<td>2,694.01</td>
<td>3362</td>
<td>3017.01</td>
<td>3362</td>
<td>3463.01</td>
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<tr>
<td>5</td>
<td>3,153.01</td>
<td>3935</td>
<td>3531.01</td>
<td>3935</td>
<td>4053.01</td>
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<tr>
<td>6</td>
<td>3,611.01</td>
<td>4507</td>
<td>4045.01</td>
<td>4507</td>
<td>4643.01</td>
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<tr>
<td>7</td>
<td>4,071.01</td>
<td>5081</td>
<td>4561.01</td>
<td>5081</td>
<td>5235.01</td>
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<tr>
<td>8</td>
<td>4,532.01</td>
<td>5657</td>
<td>5077.01</td>
<td>5657</td>
<td>5827.01</td>
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<tr>
<td>Extra Person</td>
<td>576</td>
<td>576</td>
<td>576</td>
<td>576</td>
<td>663</td>
</tr>
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</table>
# Kansas Medical Assistance Standards

## Caretaker Medical

<table>
<thead>
<tr>
<th>Household Size</th>
<th>38% Caretakers and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>377</td>
</tr>
<tr>
<td>2</td>
<td>508</td>
</tr>
<tr>
<td>3</td>
<td>639</td>
</tr>
<tr>
<td>4</td>
<td>770</td>
</tr>
<tr>
<td>5</td>
<td>901</td>
</tr>
<tr>
<td>6</td>
<td>1032</td>
</tr>
<tr>
<td>7</td>
<td>1164</td>
</tr>
<tr>
<td>8</td>
<td>1295</td>
</tr>
<tr>
<td>Extra Person</td>
<td>132</td>
</tr>
</tbody>
</table>

## Medically Needy – PW and Children

<table>
<thead>
<tr>
<th>Household Size</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>475</td>
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<tr>
<td>2</td>
<td>475</td>
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<tr>
<td>3</td>
<td>480</td>
</tr>
<tr>
<td>4</td>
<td>497</td>
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<tr>
<td>5</td>
<td>558</td>
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<tr>
<td>6</td>
<td>619</td>
</tr>
<tr>
<td>7</td>
<td>680</td>
</tr>
<tr>
<td>8</td>
<td>741</td>
</tr>
<tr>
<td>Extra Person</td>
<td>61</td>
</tr>
</tbody>
</table>
The current monthly standards for 2 people:

- HCB5/Thousands/MF: $2,077.00
- Institutional/Thousands/PACE: $1,245.00

- The current monthly standards for 1 person:

- Institutional/HCB5/Thousands/PACE: $2,199.00

8/27/00. The HCB5 standard is applicable beginning the month the choice form is signed or as per
8/11/93. The HCB5 standard is applicable beginning the month the case begins or the following month as specified in

Deeming Equation in which the month the case begins or the following month as specified in

The Institutional standard is applicable in determining eligibility in which the month the case begins or the following month as specified in

See Section 8140 and 8260 for application of the standards. The Institutional standard is applicable

<table>
<thead>
<tr>
<th>For each additional person, add $671</th>
<th>Extra Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 mos.</td>
</tr>
<tr>
<td>446</td>
<td>0 - 1,680</td>
</tr>
<tr>
<td>417</td>
<td>1,680.01 - 2,266</td>
</tr>
<tr>
<td>347</td>
<td>2,266.01 - 3,477</td>
</tr>
</tbody>
</table>

Number of Persons in Independent Living

<table>
<thead>
<tr>
<th></th>
<th>1 mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0 - 200%</td>
</tr>
<tr>
<td>4</td>
<td>200% - 1,35%</td>
</tr>
<tr>
<td>6</td>
<td>1,35% - 2,12%</td>
</tr>
<tr>
<td>8</td>
<td>2,12% - 3,47%</td>
</tr>
</tbody>
</table>

6 mos.
4 mos.
3 mos.
2 mos.
1 mos.

Standards for Long Term Care/HCB5

Standards for Independent Living

Kansas Medical Assistance Standards

2. Non-MAGI Programs
The current monthly standard for 2 people:

$235.00

The current monthly standard for 1 person:

$250.00

The median program small include either a single adult or a married couple living together as noted in 7430 (g).

For premium purposes, the following standards apply:

<table>
<thead>
<tr>
<th>Poverty Level Index</th>
<th>Monthly Net Income</th>
<th>3 Person Household</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.40</td>
<td>0 - 1,350</td>
<td></td>
<td>3</td>
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<tr>
<td>40.00</td>
<td>0 - 1,350</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>29.70</td>
<td>0 - 1,350</td>
<td></td>
<td>1</td>
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</table>

To be eligible, the total countable income must not exceed the monthly 300% poverty level standard for the appropriate size household.

Eligible: Individual with eligible spouse - both in household of another
Eligible: Individual in Medical Needs LTC placement
Eligible: Individual in household of another
Eligible: Individual in Down Home
Eligible: Individual with eligible spouse in home
Eligible: Individual in Medical Needs LTC placement

Kansas Medical Assistance Standards

Rev. 05-16